explanted endografts revealed streptococcus viridans infection.

Conclusions: This study presents five cases of EVAR endograft infection from an infectious or inflammatory condition, leading to AEF formation. This reinforces the importance of aggressive surveillance and antibiotic prophylaxis for dental and other invasive procedures to prevent a potentially fatal complication after EVAR.

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PS60.

Complex Aortic Endografting Requires a New Classification System: A Proposed New Zonal System

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Objectives: Complex aortic endografting has emerged as an alternative to open surgery for pararenal, suprarenal and thoracoabdominal aneurysms. Definitions of these aneurysms vary and are often related to clamp placement. With the emergence of complex endovascular options for repair, defining aneurysm morphology based on clamp placement is now obsolete and a new classification system should be developed.

Methods: We propose division of the visceral segment into zones based on the anatomy and location of the endovascular "seal-zone":

- Zone 0: below the lowest renal artery
- Zone 1: between renal arteries
- Zone 2: between the upper renal artery and SMA
- Zone 3: between the SMA and CA
- Zone 4: above the CA

We present the results of our case series of complex endovascular repair based on the above classification.

Results: Between April 2008 and August 2010, 145 EVAR were performed at a regional centre in the UK. We classified 84 aneurysms as Zone 0, 20 as Zone1/2, 25 as Zone 3 and 16 as Zone 4. Mean operative times were 5.1, 6.9 and 8.6 hours for Zones 1-2, 3 and 4 respectively. Mean number of target vessels were 1.75 for zone 1-2 aneurysms, 2.9 for zone 3 and 3.5 for zone 4 aneurysms. Target vessel patency was 97% for Zone 1-2, 96% for Zone 3 and 89% for Zone 4. Morbidity in Zone 1-2 was 35% compared to 48% in Zone 3 and 38% in Zone 4. 30 day mortality was 0% in Zone 1-2, 16% in Zone 3 and 13% in Zone 4.

Conclusions: Higher seal-zones reflect more complex procedures with more visceral vessels involved and are associated with longer operations, more morbidity and mortality. The proposed seal-zone classification allows for accurate and reproducible differentiation between aneurysms requiring complex endovascular repair, replacing the surgical clamp-based classification.

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PS62.

A Retrospective Review of the Prevalence, Growth Rate, and Treatment Outcomes of Aortoiliac Aneurysms in Orthotopic Heart Transplant Recipients

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Objectives: To study the prevalence, growth rate, and treatment outcomes of abdominal aortic(AAA) and iliac(IA) aneurysms in adult orthotopic heart transplant (OHT) recipients at a high-volume transplant center.

Methods: Over a 10-year period, adult OHT recipients who underwent CT scanning pre and post-transplant were evaluated for AAA and IA aneurysms.

Results: Of the 638 OHT patients, 319 underwent a CT scan of the abdomen; 32 (10%) with aneurysms were identified. Patients with ischemic cardiomyopathy (ICM), who represent 41% of our OHT population, had a significantly elevated prevalence (20%) of AAA/IA. The prevalence of aneurysm in the non-ICM patients was not elevated when compared to the general population. The mean AAA and IA diameters were 37 ± 9 and 22 ± 3 mm, respectively. Serial imaging in 14 patients demonstrated an infrarenal growth rate of 7 ± 5 mm/year. Seven aneurysms, with a mean diameter of 52 ± 5 mm, underwent repair; six elective operations (3 endovascular, 3 open) resulted in no mortality. One patient died after emergent operation for a mycotic AAA.

Conclusions: This is the largest reported series and the only using cross-sectional imaging for aortoiliac aneurysms in OHT patients. We recommend aneurysm screening for ICM patients prior to heart transplant. Aneurysm growth rate is greater in transplant patients and surveillance is indicated, even for small aneurysms. Elective repair resulted in a similar morbidity and mortality to non-transplant patients and we recommend managing these patients using standard aortic aneurysm guidelines.

AAA/IA Incidence by Cardiomyopathy Type and Location

	Patients	*AI*	*IR*	*I*	*SR*
Total	32 (10%)	6 (2%)	19 (6%)	5 (2%)	2 (1%)
Ischemic Cardiomyopathy	24 (20%)	6 (5%)	14 (12%)	4 (3%)	0
Non-ischemic cardiomyopathy	8 (4%)	0	5 (3%)	1 (1%)	2 (1%)

AI=aortoiliac, IR=infrarenal, I=iliac, SR=suprarenal